EXHIBIT C

Only the Westlaw citation is currently available.

United States District Court, E.D. Tennessee.

UNITED STATES of America, Plaintiff,
v.
Estate of William T. ROGERS; Gayle M. Rogers; James C. Callaway, Jr.; Charitable Healthcare Foundation, Inc. f/k/a Superior Home Health Care of Chattanooga, Inc.; and Alpha Medical, Inc., Defendants.

No. 1:97CV461.

June 28, 2001.

MEMORANDUM AND ORDER

EDGAR, Chief District J.

*1 Plaintiff United States of America brings this action under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, common law, and the Fair Debt Collection Procedures Act, 28 U.S.C. §§ 3001-3008. [Court File No. 179, Amended Complaint]. This suit involves alleged false and/or fraudulent Medicare provider cost reimbursement claims that defendants William Rogers, James Callaway, Jr. ("Callaway"), The Charitable Healthcare Foundation, Inc. ("Charitable") formerly known as Superior Home Health Care of Chattanooga, Inc., and Alpha Medical, Inc. ("Alpha") submitted or caused to be submitted to, or conspired to get allowed and paid by, the United States Department of Health and Human Services ("HHS"), Health Care Financing Administration ("HCFA"), for purposes of obtaining payment or the approval of payment of false and fraudulent claims in violation of the FCA and common law.

The complaint is summarized in the opinion rendered by this Court on April 12, 1999 [Court File No. 115] and need not be repeated here. The United States subsequently filed an amended complaint on December 5, 2000, adding a new claim (Count VII) under the Fair Debt Collection Procedures Act. [Court File No. 179].

In a nutshell, this suit involves claims for reimbursement of costs under the Medicare program made by six Tennessee home health care agencies collectively referred to as the Superiors. Each of these Medicare providers contracted with Alpha to furnish them with management services. The Superiors submitted cost reports and claims to HCFA for fiscal years 1990-1993 seeking reimbursement for the management fees they paid to Alpha. The heart of the complaint is the government's allegation that Alpha and its owner, William Rogers, were "related" to the Superiors by virtue of certain business and personal relationships that existed between the owners, corporate officers, and directors of the Superiors and Alpha. Plaintiff contends that claims submitted by the Superiors to HCFA for 1990-1993 were false and fraudulent in that they included management fees paid to Alpha which were not properly reimbursable costs because the Superiors were related to Alpha and Alpha's owner, William Rogers, within the meaning of Medicare's rules and regulations. 42 C.F.R. § 413.17 .

I. *Pending Motions*

The following motions are before the Court:

(1) Defendants' motion to dismiss the complaint under FED. R. CIV. P. 12(b)(6). [Court File Nos. 21, 26];

(2) Defendants' motion for summary judgment based upon collateral estoppel. [Court File No. 111];

(3) Defendants' motion for summary judgment under based on HCFA's decision not to reopen the fiscal intermediary's determinations or Notice of Program Reimbursements for fiscal years 1990-1993 pursuant to 42 C.F.R. § 405.1885(d).

[Court File No. 185];

(4) Defendants' Rule 12(b)(6) motion to dismiss the complaint or, in the alternative, Rule 56 motion for summary judgment. [Court File No. 108];

(5) Defendants' motion for partial summary judgment declaring that PRM-1 § 1011.2 does not apply in this case. {Court File No. 105];

***2** (6) Plaintiff's motion for partial summary judgment on issue of whether there is an irrebuttable presumption that Alpha was related to Superior Home Health Care of Livingston, Inc. and Superior Home Health Care of East Tennessee, Inc. [Court File No. 35];

(7) Defendants' motion for partial summary judgment on the false bid letters. [Court File No. 187];

(8) Plaintiff's motion in limine to exclude evidence and argument at trial concerning the purported reasonableness of Alpha's management fees. [Court File No. 36];

(9) Plaintiff's motion to limit discovery on the purported reasonableness of Alpha's management fees [Court File No. 37] and the plaintiff's objections to the Magistrate Judge's report and recommendation on said motion. [Court File No. 91]; and

(10) Plaintiff's request for oral argument. [Court File No. 183].

In addition, the Court will address the questions whether attorney John Konvalinka will be called to testify as a witness at trial, and whether bifurcation of liability and damages at trial is necessary and appropriate.

II. Defendants' Motion To Dismiss Complaint *Under Rule 12(b)(6) [Court File Nos. 21 and 26]*

We begin with the defendants' motion to dismiss the complaint pursuant to FED. R. CIV. P. 12(b)(6). [Court File Nos. 21, 26]. The motion is DENIED.

A. *Standard of Review*

FED. R. CIV. P. 12(b)(6) provides that a complaint may be dismissed if it fails to state a claim upon which relief can be granted. The purpose of Rule 12(b)(6) is to permit a defendant to test whether, as a matter of law, the plaintiff is entitled to relief even if everything alleged in the complaint is true. *Mayer v. Mylod,* 988 F.2d 635, 638 (6th Cir.1993); *Nishiyama v. Dickson County, Tennessee,* 814 F.2d 277, 279 (6th Cir.1987). A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of the complaint which would entitle the plaintiff to relief. *Haines v. Kerner,* 404 U.S. 519 (1972); *Conley v. Gibson,* 355 U.S. 41, 45-46 (1957); *Saglioccolo v. Eagle Ins. Co.,* 112 F.3d 226, 228 (6th Cir.1997); *Columbia Natural Resources, Inc. v. Tatum,* 58 F.3d 1101, 1109 (6th Cir.1995), *cert. denied,* 517 U.S. 1163 (1996).

To preclude dismissal under Rule 12(b)(6), a complaint must contain either direct or inferential allegations which comprise all of the essential, material elements necessary to sustain a claim for relief under some viable legal theory. *Lewis v. ACB Business Services, Inc.,* 135 F.3d 389, 406 (6th Cir.1998); *Columbia Natural Resources,* 58 F.3d at 1109; *Allard v. Weitzman (In re DeLorean Motor Co.),* 991 F.2d 1236, 1240 (6th Cir.1993); *Scheid v. Fanny Farmer Candy Shops, Inc.,* 859 F.2d 434, 436 (6th Cir.1988). The Court is required to construe the complaint in the light most favorable to the plaintiff and to accept all well-pleaded allegations of fact as being true. *Scheur v. Rhodes,* 416 U.S. 232 (1974); *Columbia Natural Resources,* 58 F.3d at 1109; *Mayer,* 988 F.2d at 638; *Collins v. Nagle,* 892 F.2d 489, 493 (6th Cir.1989). When a factual allegation is capable of more than one reasonable inference, it must be construed in the plaintiff's favor. *Saglioccolo,* 112 F.3d at 228; *Columbia Natural Resources,* 58 F.3d at 1109. The Court may not grant a Rule 12(b)(6) motion to dismiss simply because the Court does not believe the allegations of fact in the complaint. *In re Sofamor Danek Group, Inc.,* 123 F.3d 394, 400 (6th Cir.1997), *cert. denied,* 118 S.Ct. 1675, 140 L.Ed.2d 813 (1998); *Saglioccolo,* 112 F.3d at 228-29; *Columbia Natural Resources,* 58 F.3d at 1109; *Allard,* 991 F.2d at 1240. The Court does not, however, have to accept as true mere legal conclusions and unwarranted inferences of fact. *Lewis,* 135 F.3d at 405; *Grindstaff v. Green,* 133 F.3d 416, 421 (6th Cir.1998); *Columbia Natural*

Resources, 58 F.3d at 1109; *Morgan v. Church's Fried Chicken,* 829 F.2d 10, 12 (6th Cir.1987).

B. Disputed Interpretation of Administrative Regulations: *"Reasonable Interpretation" Approach to Falsity Under the FCA*

*3 Defendants move to dismiss Counts I--IV of the complaint on the ground that they fail to state a viable claim under the FCA. Count I avers the defendants are liable under 31 U.S.C. § 3729(a)(1) in that they knowingly presented, or caused to be presented, to the United States government false and fraudulent claims for payment or approval. Count II alleges the defendants are liable pursuant to 31 U.S.C. § 3729(a)(2) in that they knowingly made, used, or caused to be made and used, false records or false statements to get false and fraudulent claims allowed or paid by the government. It is alleged in Count III that the defendants are liable pursuant to 31 U.S.C. § 3729(a)(3) on the theory that they conspired with each other and with other persons to defraud the government by getting false or fraudulent claims allowed or paid. Count IV asserts a reverse FCA claim under 31 U.S.C. § 3729(a)(7) in that the defendants knowingly made, used, or caused to be made or used, false records or false statements for the purpose of concealing, avoiding, or decreasing an obligation to pay or transmit money to the government. [Court File No. 179].

It is important to distinguish between the different elements of scienter and falsity. *See, e.g., United States ex rel. Compton v. Midwest Specialties, Inc.,* 142 F.3d 296, 301 (6th Cir.1998). For purposes of the FCA, a person acts "knowingly" if he: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud the government is required. 31 U .S.C. § 3729(b); *Compton,* 142 F.3d at 303. Reckless disregard has been construed as an extreme version of ordinary negligence rather than a lesser form of intent. *United States v. Krizek,* 111 F.3d 934, 942 (D.C.Cir.1997); *United States ex rel. Augustine v. Century Health Services,* 136 F.Supp.2d 876, 887-88 (M.D.Tenn.2000). Simple negligence and innocent mistakes do not meet the level of scienter required by the FCA. *Id.; United States v. Boeing Co.,* 100 F.Supp.2d 619, 626 (S.D.Ohio 2000).

Defendants urge this Court to adopt a "reasonable interpretation" approach to the element of falsity. Defendants contend they are not liable under the FCA because their statements and certifications that the Superiors were unrelated to Alpha were based on their reasonable interpretation of HCFA's rules and regulations, and the then-existing decisions of the Provider Reimbursement Review Board ("PRRB"). Defendants say that the Medicare "related-party" rules and regulations are complex, subjective, and difficult to understand and apply. It is argued that the FCA was not enacted to punish persons for merely disagreeing with the federal government over the meaning of administrative regulations. Defendants characterize the instant controversy as merely a regulatory dispute with HCFA over the correct interpretation of HCFA's regulations which should not be the subject of a FCA suit.

*4 The FCA requires the plaintiff to prove that there has been a false record or statement presented to the government which is known by the defendants to be false. Falsity is an essential element of a FCA cause of action. The defendants' main argument is that a claim is not false under the FCA if there is any reasonable interpretation of the statute or regulation under which the claim would be true. Where the issue of truth or falsity of a particular statement turns on the meaning and interpretation of a regulation, defendants contend the statement is not "false" for purposes of the FCA unless it is false under all reasonable interpretations. Defendants rely primarily upon *Hagood v. Sonoma County Water Agency,* 81 F.3d 1465, 1477 (9th cir.1996), and also cite *United States ex rel. Lindenthal v. General Dynamics Corp.,* 61 F.3d 1402, 1412 (9th Cir.1995); *United States v. Data Translation, Inc.* 984 F.2d 1256, 1267 (1st Cir.1992); *United States v. Race,* 632 F.2d 1114 (4th Cir.1980); *United States v. Anderson,* 579 F.2d 455, 460 (8th Cir.1978).

The defendants' reliance on *Hagood,* 81 F.3d at 1477, and this line of precedent is misplaced. The Court instead follows the Ninth Circuit's more recent decision in *United States ex rel. Oliver v. Parsons Co.,* 195 F.3d 457 (9th Cir.1999), *cert. denied,* 530 U .S. 1228 (2000). In *Oliver,* the Ninth Circuit discusses its prior opinion in *Hagood* and rejects the same argument being raised here by the defendants with regard to the "reasonable interpretation" approach to falsity. *Oliver,* 195 F.3d at 463, explains that *Hagood* does not stand for the proposition that a defendant's reasonable interpretation of a regulation precludes falsity under the FCA. In *Hagood,* a statute granted discretion in deciding the cost allocation that the plaintiff claimed was false. *Oliver* recognizes there is a critical distinction where the regulations involved are discretionary. *Oliver* holds that where technical and complex administrative regulations are not discretionary, their meaning is ultimately a matter of judicial interpretation. It is the defendant's compliance or lack of compliance with the nondiscretionary regulations, as interpreted by the courts, that determines whether the defendant's conduct results in the submission of false claims under the FCA. *Id.* at 463. While the reasonableness of a defendant's interpretation of nondiscretionary regulations may be relevant to the separate issue of scienter and whether that defendant knowingly submitted a false claim, the issue of falsity is determined by whether the defendant's statements to the government were true and accurate in light of the applicable law. *Id.*

This Court agrees with and follows *Oliver.* In this case, we are dealing with HCFA regulations that are not discretionary. The Court rejects the defendants' argument that Counts I--IV of the complaint should be dismissed. With regard to the specific element of falsity under the FCA, it is immaterial whether the defendants did or did not make reasonable interpretations of the applicable HCFA rules and regulations governing the related-party issue. As the Ninth Circuit explains in *Oliver,* 195 F.3d at 462-64, the defendants' contention that they made a reasonable interpretation of HCFA's related-party rules and regulations only goes to the scienter element and whether the defendants acted "knowingly" as defined in 31 U.S.C. § 3729(b). The factual issue of scienter is a matter for the jury to determine at trial. Accordingly, the defendants' Rule 12(b)(6) motion on this point is DENIED.

C. *Expression of Legal Opinion or False Statement?*

*5 In the alternative, defendants contend that Counts I--IV of the complaint should be dismissed because when they stated and certified to HCFA and the fiscal intermediary ("FI") that the Superiors and Alpha were not related, it was not a statement of fact but rather an expression of the defendants' legal opinion based on their reasonable interpretation Medicare regulations. It is argued that legal opinions cannot be actionable as false statements or claims under the FCA. Defendants insist that Congress did not intend for the FCA to penalize persons for good faith disputes over legal questions. Defendants cite *Tyger Constr. Co., Inc. v. United States,* 28 Fed. Cl. 35, 55-56 (Cl.Ct.1993) (party's certification that it had substantially complied with contract specifications was expression of legal opinion which is not covered by the FCA); and *Hagood,* 81 F.3d at 1477-79 (taking advantage of a disputed legal issue does not give rise to FCA liability). In *Tyger,* the Court of Federal Claims reasoned that attaching FCA liability to expressions of legal opinion would have an impermissible stifling effect on the presentation of legitimate claims to the government. *Id.* at 56.

This argument fails because a statement or certification to HCFA and the FI that the Superiors and Alpha were not related is a statement of fact and not purely the expression of legal opinions. At the very least, it is a mixed statement of fact and legal opinion. When the Superiors stated they were unrelated to Alpha for purposes of applying HCFA's regulations, they in effect said that the Superiors were not to a significant extent associated or affiliated with Alpha, that the Superiors did not have control over Alpha, and that Alpha did not control the Superiors. These are essentially statements of fact. In determining whether the Superiors and Alpha were related under 42 C.F.R. § 413.17, factual issues concerning associations, affiliations, common ownership and control must be resolved.

Moreover, the FCA prohibits the knowing submission of false "claims" to the federal government. The Supreme Court has given the FCA an expansive reading. The FCA reaches all fraudulent attempts to cause the government to pay out sums of money. *United States v. Neifert-White Co.,* 390 U.S. 228, 232-33 (1968); *American Textile Mfrs. Institute v. The Limited,* 190 F.3d 729, 733 (6th Cir.1999), *cert. denied,* 529 U.S. 1054 (2000); *Harrison v. Westinghouse Savannah River Co.,* 176 F.3d 776, 788 (4th Cir.1999). While the FCA aims to protect the federal government's funds and property from fraudulent claims, it is not designed to punish every kind of fraud committed against the government. *United States v. McNinch,* 356 U.S. 595, 599 (1958); *Harrison,* 176 F.3d at 785. For a false statement to be actionable under the FCA, it must constitute a false or fraudulent claim. The FCA imposes liability not for the underlying fraudulent activity or for the government's wrongful payment of public funds, but rather attaches liability to the fraudulent claim for payment. *Id.; United States v. Rivera,* 55 F.3d 703, 709 (1st Cir.1995). The central question in every FCA case is whether the defendant has presented a false or fraudulent claim to the government.

*6 A false certification by the Superiors that they were unrelated to Alpha and were in compliance with HCFA regulations in submitting their Medicare provider cost reports to HCFA and the FI may constitute a false claim and support a cause of action under the FCA. Violations of the FCA may occur when a defendant makes a false certification that the claimant is in compliance with statutes and administrative regulations in an effort to obtain approval or payment of a claim. *See, e.g., Harrison,* 176 F.3d at 786-87; *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.,* 125 F.3d 899, 902 (5th Cir.1997); *United States ex rel. Pogue v. American Healthcorp., Inc.,* 914 F.Supp. 1507, 1509, 1513 (M.D.Tenn.1996); *United States v. Incorporated Village of Island Park,* 888 F.Supp. 419, 434-36, 440-41 (E.D.N.Y.1995); *United States ex rel. Fallon v. Accudyne Corp.,* 880 F.Supp. 636, 638 (W.D.Wis.1995). FCA liability may not be based merely on noncompliance with statutes and regulations. FCA liability for a false certification will lie only if compliance with a statute or regulation was a prerequisite to gaining a benefit, and the defendant affirmatively certifies such compliance. Where the government has conditioned payment of a claim upon a claimant's certification of compliance with a statute or regulation, a claimant submits a false or fraudulent claim within the purview of the FCA when the claimant falsely certifies compliance with that statute or regulation. *Harrison,* 176 F.3d at 787; *Thompson,* 125 F.3d at 902.

The Court finds that the plaintiff's complaint does state a claim under the FCA upon which relief can be granted. The defendants' Rule 12(b)(6) motion to dismiss Counts I--IV of the complaint on the theory that the defendants expressed only a legal opinion and did not make a false claim or a false statement of fact is without merit.

D. Did Defendants Receive Fair Notice of the Government's Interpretation of HCFA Regulations Consistent with *Constitutional Right to Due Process?*

Defendants next contend they did not have fair notice of the government's alleged novel, arbitrary interpretation of HCFA's related-party regulations. Defendants argue that to impose treble damages and substantial penalties upon them under the FCA would violate their right to due process of law as guaranteed by the Due Process Clause in the Fifth Amendment to the United States Constitution.

It is a bedrock principle of due process that statutes and regulations which govern conduct are required to give fair, adequate notice or warning of what they command and prohibit. *See e.g. Ohio Cast Products v. Occupational Safety & Health,* 246 F.3d 791, 798 (6th Cir.2001). To comport with due process, laws must give a person of ordinary intelligence a reasonable opportunity to know what is prohibited so that he or she may take action to comply with the law. *Hoffman Estates v. Flipside, Hoffman Estates,* 455 U.S. 489, 498 (1982); *Grayned v. City of Rockford,* 408 U.S. 104, 108 (1972); *Diebold, Inc. v. Marshall,* 585 F.2d 1327, 1335 (6th Cir.1978). A regulation is not unconstitutionally vague if it is capable of a limited interpretation such that ordinary people can reasonably understand what conduct is prohibited, and those government officials enforcing the law are provided with clear standards to constrain them from acting in an arbitrary, discriminatory manner. *Grayned,* 408 U.S. at 108-109; *United States v. Erickson,* 75 F.3d 470, 475 (9th Cir.1996).

*7 Statutes and regulations must deal with untold and unforeseen variations in factual situations. The practical necessities of discharging the business of government involved in the administration of the Medicare program inevitably limit the specificity with which the Secretary of HHS and HCFA can spell out precisely when organizations are "related" and what costs are reasonable and can be reimbursed to Medicare providers. "Consequently, no more than a reasonable degree of certainty can be demanded. Nor is it unfair to require that one who deliberately goes perilously close to an area of proscribed conduct shall take the risk that he may cross the line." *Boyce Motor Lines v. United States,* 342 U.S. 337, 340 (1952); *see also United States v. Midwest Fireworks Mfg. Co., Inc.,* 248 F.3d 563, 568 (6th Cir.2001) *United States v. Sun and Sand Imports, Ltd., Inc.,* 725 F.2d 184, 187-88 (2nd Cir.1984). HCFA's regulations are not impermissibly vague simply because it may be difficult to determine whether marginal cases fall within their scope. *Midwest Fireworks,* 248 F.3d at 568; *Sun and Sand Imports,* 725 F.2d at 187. When HCFA and HHS promulgate Medicare regulations, the Due Process Clause does not impose on them drafting requirements of impossible specificity and mathematical precision. *United States v.. Powell,* 423 U.S. 87, 94, 96 (1975); *Diebold,* 585 F.2d at 1336.

The degree of vagueness that the United States Constitution tolerates depends on the nature of the regulation in dispute. Administrative regulations which govern economic or commercial activity, without implicating the First Amendment, are subject to a less strict vagueness test. *Village of Hoffman Estates,* 455 U.S. at 498-99; *Midwest Fireworks,* 248 F.3d at 568; *Kentucky Div., Horsemen's Benevolent & Protective Ass'n, Inc. v. Turfway ParkRacing Ass'n, Inc.,* 20 F.3d 1406, 1413 (6th Cir.1994); *Diebold,* 585 F.2d at 1335- 36. Greater leeway is allowed under the Due Process Clause in the field of regulations governing economic and commercial activity. The fairness of a regulation is subject to a less stringent standard of due process review in the absence of criminal penalties and First Amendment implications. *Papachristou v. City of Jacksonville,* 405 U.S. 156, 162 (1972); *Erickson,* 75 F.3d at 475; *Diebold,* 585 F.2d at 1337. The less stringent standard of due process review applies to the Medicare regulations.

In *Ohio Cast Products,* 246 F.3d at 799, the Sixth Circuit identifies three factors that must be weighed in evaluating the question of fair notice: (1) artful vs. inartful drafting of the regulation; (2) common understanding and commercial practice; and (3) confirmation of industry practice by a pattern of administrative enforcement. *See also Diebold,* 585 F.2d at 1336-37. The determination is made with reference to what a reasonable, prudent Medicare provider familiar with the Medicare program could reasonably be expected to know concerning how HCFA's related-party regulations are interpreted and applied by HCFA. *Cf. Martin v. American Cyanamid Co.,* 5 F.3d 140, 146 (6th Cir.1993).

***8** The second and third factors in *Ohio Cast Products* make it very difficult, if not impossible, for this Court to grant a Rule 12(b)(6) motion to dismiss the entire complaint based on the defendants' due process/lack of fair notice argument. For the Court to be able to make a properly informed decision about what a reasonable Medicare provider would be expected to know regarding the interpretation, application, and enforcement of HCFA's related-party regulations, the Court needs to consider proof outside the complaint. For example, the Court would need to consider testimony from Medicare providers about what were the commonly accepted and commonly understood practices within the Medicare program in 1990-1993. In addition, the Court could consider expert testimony from HCFA officials, *e.g.,* Bruce Robert Oliver, Director of HCFA's Division of Cost Reporting, and the defendants' expert, James J. Folz [Court File No. 95]. Therefore, to the extent the defendants move the Court to find that the government's interpretation of HCFA's regulations, as expressed in its complaint, are unreasonable and contrary to the common, prevailing understanding of Medicare providers that existed in 1990-1993, the Court cannot make such a finding pursuant to Rule 12(b)(6) from the face of the complaint. When ruling on the Rule 12(b)(6) motion, the Court is confined to reviewing the complaint without considering other facts, documents, and proof extraneous to the complaint.

The Rule 12(b)(6) motion to dismiss the complaint on the ground of violation of due process through lack of fair notice is DENIED. After reviewing the complaint and the plain language of HCFA's related-party rules and regulations, 42 C.F.R. § 413.17 and PRM-1 §§ 1000 through 1004.4, the Court concludes that the regulations did give fair notice and adequate warning to the defendants with regard to the circumstances when an organization will be deemed "related to the provider" for the purpose of awarding reimbursable costs. *See United States v. Woodley,* 9 F.3d 774, 778 (9th Cir.1993). The regulations define and explain what is an organization related to the provider by common ownership or control with sufficient clarity to give the defendants reasonable, fair notice consistent with the constitutional guarantee of due process. A reasonable Medicare provider who reads C.F.R. § 413.17 and the PRM, and who is familiar with the Medicare program, standing in the defendants' shoes in 1990-1993, would recognize that the regulations could reasonably be interpreted by HCFA and the government to determine that the Superiors and Alpha were related.

According to the defendants, certain authoritative pronouncements by HCFA and the PRRB in other similar Medicare provider cases permit the very relationships between the Superiors and Alpha which are detailed in the plaintiff's complaint. Defendants assert that interpretations of the related-party regulations by HCFA and the PRRB in other similar cases are highly relevant on the due process question because the constitutional adequacy of notice given by a regulation must be measured by common understanding and commercial practice. *Diebold,* 585 F.2d at 1336. The Court has reviewed the administrative decisions cited by the defendants in their motion [Court File Nos. 21 and 26, pp. 11-14], including the PRRB decision in *Tennessee Nursing Medical Services, Inc. (Nashville, Tenn.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina,* Medicare and Medicaid Guide (CCH) ¶ 41,760 (Sept. 28, 1993). This Court is not persuaded, based on these administrative decisions, that the government's interpretation of HCFA's related-party regulations in the instant case is so novel and arbitrary that it deprives the defendants' of their constitutional right to due process by failing to give them fair notice. Defendants conveniently overlook other administrative decisions which are adverse to them. *See, e.g.,* HCFA Deputy Administrator Decision in *Three Rivers Convalescent Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Southwest Ohio,* Medicare and Medicaid Guide (CCH) ¶ 34,921 (July 3, 1985). [Court File No. 191, Ex. D].

***9** Defendants further argue that confidence in the clarity of HCFA's regulations is shaken by HCFA's continuing inability to settle on a clear definition of the term "related" as applied to the Superiors and Alpha. Defendants cite *General Electric Co. v. United States Environmental Protection Agency,* 53 F.3d 1324, 1332 (D.C.Cir.1995) (it is unlikely that regulations provide adequate due process notice when different divisions of enforcing agency disagree about their meaning); and *Diamond Roofing Co. v. OSHRC,* 528 F.2d 645, (5th Cir.1976) (OSHA safety regulation deemed unconstitutionally vague as applied because agency came to inconsistent conclusions about regulation's meaning). Defendants contend that the government, acting through HFCA's fiscal intermediaries, on multiple occasions has determined that the Superiors are not related to Alpha. Defendants point out that the related-party issue was resolved in favor of the Superiors and Alpha in a prior proceeding before the PRRB. *See* Plaintiff's Amended Complaint, ¶¶ 25. Defendants object that the government is now arbitrarily changing its view on the related-party issue and seeks to impose damages and penalties upon the defendants pursuant to the FCA without giving them fair advance notice that Alpha and the Superiors might be considered related organizations. It is argued that due process and the requirement of fair notice should preclude the government's choice of litigation under the FCA as the means of first declaring its belief that the Superiors and Alpha are related.

The Court rejects these arguments as a basis for dismissing the plaintiff's complaint under Rule 12(b)(6). In determining whether the complaint states viable claims upon which relief can be granted, it makes no difference whether the FI and the PRRB did or did not make previous determinations that the Superiors and Alpha are unrelated. The complaint avers that these prior decisions by the FI and the PRRB were obtained as a result of the defendants' fraudulent conduct. The complaint alleges the defendants are liable under the FCA and common law for making false or fraudulent claims and perpetrating a fraud on the federal government in that the defendants misrepresented to HCFA and the FI the true nature and extent of Alpha's relationship with the Superiors. In reviewing the complaint pursuant to Rule 12(b)(6), the Courts accepts the plaintiff's allegations as being true.

When the defendants adroitly argue that they are being deprived of due process on the theory that the government is being inconsistent in its interpretation and application of HCFA's regulations, defendants rely on previous decisions by the FI and the PRRB which the complaint avers were obtained through the defendants' own fraud and misrepresentations. The defendants' position is not persuasive. To the extent that the government's interpretation of HCFA's regulations is alleged by the defendants to be inconsistent with prior decisions by the FI and the PRRB allowing the Superiors to be reimbursed for Alpha's management fees, then a fair reading of the complaint is that any such inconsistency is due to the defendants making fraudulent misrepresentations to the FI and the PRRB to the effect that the Superiors and Alpha were not related. This does not amount to the defendants being deprived of due process on the theory that HCFA and the United States Department of Justice are unable to arrive at a consistent interpretation and application of HCFA's regulations.

E. "Special Circumstances" Exception: Does Application of Related-Party Regulations Contravene *the Primary Purpose of the Medicare Statutes?*

***10** Defendants contend the entire complaint should be dismissed under Rule 12(b)(6) because, even if we assume *arguendo* that the Superiors and Alpha were related, allowing the enforcement of the related-party regulations to impose FCA liability on these defendants and to preclude the Superiors from hiring a cost-effective, high quality management company (Alpha) contravenes the fundamental purpose and overriding goal of the Medicare statutory scheme which is to ensure the efficient delivery of quality, reasonably priced health care services to the needy. It is argued that the government's effort to apply the related-party regulations to limit reimbursement of the cost of Alpha's management fees to the Superiors should be declared invalid on the theory that the government's exclusive focus on business and personal associations among the health care providers frustrates the Medicare program's main purpose by ignoring the low cost and high quality of the management services Alpha provided to the Superiors.

Defendants say this case falls within a judicially crafted "special circumstances" exception adopted by some federal courts. *Northwest Hospital, Inc. v. Hospital Service Corp.,* 687 F.2d 985 (7th Cir.1982) ; *Trustees of Indiana University v. United States,* 618 F.2d 736 (Ct.Cl.1980); *Richlands Medical Ass'n v. Harris,* 651 F.2d 931, 935 (4th Cir.1981); *South Boston General hospital v. Blue Cross of Virginia,* 409 F.Supp. 1380 (W.D.Va.1976). It is especially important to note that these cited opinions involved actions for judicial review of final administrative decisions rendered by the Secretary of HHS and they are not cases arising under the FCA. The Sixth Circuit in *Shaker v. Medical Center Hospital v. Secretary of Health,* 686 F.2d 1203, 1208-10 (6th Cir.1982), discussed and generally recognized the existence of this line of case law but the Sixth Circuit has never adopted or applied the "special circumstances" exception.

Defendants contend the "special circumstances" exception should be applied because it would be inequitable and manifestly unjust to impose treble damages and punitive sanctions upon the defendants under the FCA where the Superiors hired Alpha to provide them with reasonably priced, cost-effective management services. In an effort to establish some factual support for their position, defendants ask the Court to take judicial notice of an agreed memorandum opinion and order it entered on March 29, 1996, in an entirely different lawsuit styled *Alpha Medical, Inc. v. Home Health One, Inc. d/b/a Superior Home Care,* United States District Court for the Eastern District of Tennessee at Chattanooga, Case No. 1:93-CV-427. [Court File No. 25, Exhibit 1]. This Court signed an agreed order tendered by Alpha Medical and Home Health One which was designed to achieve a negotiated settlement of a dispute between them. Defendants assert this previous agreed order shows that, in the aftermath of a HCFA audit, both HCFA and this Court found the cost of Alpha's management fees to be reasonable and cost-efficient in compliance with the Medicare program.

***11** These arguments lack merit for the following reasons. The Sixth Circuit has not actually adopted and followed the "special circumstances" exception. The Sixth Circuit only recognizes that a few courts in other federal circuits have created and allowed such an exception to be applied in unique and very extraordinary cases. *Shaker Medical,* 686 F.2d at 1209-10; *see also, University of Cincinnati v. Heckler,* 733 F.2d 1171 (6th Cir.1984). There is no authority in the Sixth Circuit or anywhere else for applying the "special circumstances" exception in a FCA case where the government is alleging that the defendants submitted false and fraudulent claims to the government. Defendants do not cite and the

Court is not aware of any reported legal precedent where the "special circumstances" exceptions has been applied in a FCA case to grant a defendant's motion to dismiss the plaintiff's complaint pursuant to FED. R. CIV. P. 12(b)(6).

If the United States is able to prove its complaint at trial that the defendants have perpetrated a fraud on the federal government by filing false or fraudulent claims in violation of the FCA, then logic dictates that the "special circumstances" exception cannot possibly apply. A complaint brought under the FCA alleging fraud cannot be dismissed pursuant to Rule 12(b)(6) for failure to state a claim based on an application of the "special circumstances" exception which is grounded in principles of equity. To the extent the government alleges and can prove that the defendants have engaged in fraud that is actionable pursuant to the FCA, the defendants are not entitled to avoid the imposition of FCA liability by invoking the "special circumstances" exception. Fraud on the part of the defendants vitiates any claim they may have for equitable relief. It would be improper to dismiss the complaint under Rule 12(b)(6) by invoking the "special circumstances" exception because the complaint alleges that the defendants submitted false and fraudulent claims to the government for payment.

Moreover, even if we assume *arguendo* that the Sixth Circuit would adopt the "special circumstances" exception, this Court is not persuaded that these defendants have conclusively demonstrated that the facts and circumstances as averred in the complaint are so extraordinary that the exception must be applied as a matter of equity to prevent a manifest injustice and promote the Medicare program's purpose. The motion to dismiss is brought under FED. R. CIV. P. 12(b)(6) and the Court reviews the plaintiff's complaint to determine whether it adequately states a cause of action. By seeking to invoke the "special circumstances" exception, defendants want the Court to go far beyond the complaint and make a factual determination that the cost of Alpha's management fees charged to the Superiors were reasonable, fair, necessary, and deserve to be reimbursed under the Medicare program. This would clearly be improper pursuant to Rule 12(b)(6). For the Court to be able to make such sweeping findings of fact, it would require the Court to go far outside the confines of the complaint and consider numerous documents and other extraneous proof which the Court is not permitted to do pursuant to Rule 12(b)(6). To prevail on their argument that the "special circumstances" exception is applicable, the defendants must present proof outside the complaint. This is not permitted under Rule 12(b)(6) .

***12** In an effort to get around this problem, defendants urge the Court to take judicial notice of its opinion and order entered on March 29, 1996, in the case of *Alpha Medical, Inc. v. Home Health One, Inc.* As a general rule, matters outside the pleadings may not be considered by the Court in deciding a Rule 12(b)(6) motion unless the motion is converted into one for summary judgment. *Kostrzewa v.. City of Troy,*247 F.3d 633, 643 (6th Cir.2001); *Jackson v. City of Columbus,* 194 F.3d 737, 745 (6th Cir.1999); *Fugarino v. Hartford Life and Acc. Ins. Co.,* 969 F.2d 178, 182-83 (6th Cir.1992); *Friedman v. United States,* 927 F.2d 259, 261 (6th Cir.1991). However, documents attached to a Rule 12(b)(6) motion are considered part of the pleadings if they are referred to in the plaintiff's complaint and are central to the plaintiff's claim. *Jackson,* 194 F.3d at 745; *Weiner v. Klais & Co.,* 108 F.3d 86, 88 (6th Cir.1997). Courts can also consider public records and matters of which the courts may take judicial notice. *Jackson,* 194 F.3d at 745; *Lovelace v. Software Spectrum, Inc.,* 78 F.3d 1015, 1018 (5th Cir.1996) (judicial notice).

Even if this Court were to take judicial notice of the agreed order from *Alpha Medical v. Home Health One,* no Rule 12(b)(6) relief may be given to the defendants. The agreed order in *Alpha Medical v. Home Health One* concerned an entirely separate suit in which the United States government was not even a party. It did not involve the Superiors' cost reports submitted to HCFA for fiscal years 1990-1993 which are in dispute here. Based on the settlement agreement reached by the parties in the *Alpha Medical v. Home Health One* suit, this Court cannot extrapolate and now find that all of the Alpha management fees claimed in the numerous cost reports submitted to HCFA by each of the Superiors for fiscal years 1990-1993 were completely accurate, reasonable, and cost-efficient. To do so would require the Court to engage in an extraordinary, unjustified leap of logic that does not comport with Rule 12(b)(6).

The Court will not convert the defendants' Rule 12(b)(6) motion [Court File No. 21] into one for summary judgment under FED. R. CIV. P. 56. The alleged reasonableness of Alpha's management fees is immaterial and not dispositive on the plaintiff's complaint. In addition, after reviewing the record and the plaintiff's response in opposition [Court File No. 32], the Court concludes that the issue of whether Alpha's management fees were reasonable, cost-efficient, and proper under Medicare regulations could not be resolved on summary judgment anyway. There are genuine issues of fact in dispute about the reasonableness of Alpha's management fees which preclude summary judgment.

If the Superiors and Alpha were "related" within the meaning of 42 C.F.R. § 413.17 and HCFA's other rules and regulations in the Provider Reimbursement Manual ("PRM") as averred in the plaintiff's complaint, it does not make any difference whether the management fees the Superiors paid to Alpha were reasonable and fair in the open marketplace and in comparison to fees the Superiors would have otherwise paid to a non-related management company. *Cf. Kidney Center of Hollywood v. Shalala,* 133 F.3d 78, 86 (D.C.Cir.1998); *Biloxi Regional Medical Center v. Bowen,* 835 F.2d 345, 349-50 (D.C.Cir.1987); *Stevens Park Osteopathic Hosp., Inc. v. United States,* 225 Ct. Cl. 113, 633 F.2d 1373, 1379 (Ct.Cl.1980). As the District of Columbia Circuit explains in *Biloxi Regional Medical Center,* 835 F.2d at 349-50, HCFA's regulations set forth the specific methods to be used in determining the reasonable costs for which Medicare providers will be reimbursed. The clear objective of the regulations is to ensure that the Medicare program pays only for the actual cost of the services that providers render to Medicare beneficiaries--no more and no less. Consistent with this objective, the Secretary of HHS has decided that when services, facilities and supplies are furnished to a health care provider by a "related" organization, there exists a significant likelihood that the charges incurred by providers will be artificially inflated because of the absence of bona fide arms-length bargaining. HCFA's regulations prevent related entities from engaging in self-dealing at the expense of the Medicare program. *Id.; Friedman v. Heckler,* 765 F.2d 383, 387 (2nd Cir.1985); *American Hospital Management Corp. v. Harris,* 638 F.2d 1208, 1212 (9th Cir.1981).

***13** HCFA's related-party regulations do promote and serve the goals of the Medicare program by screening out both unreasonable costs and costs not actually incurred by providers. The regulations are prophylactic in the sense that they involve a considered judgment by the Secretary of HHS that the probability of abuse and fraud in transactions between related organizations is significant enough that it is more efficient to prevent the opportunity for such abuse from arising than it is to try and detect incidents of abuse or fraud on an individual, case-by-case basis. As a result, HCFA's regulations limit reimbursement for many transactions between providers and related parties to levels below what might otherwise be considered reasonable and reimbursable if the costs had instead been incurred by providers dealing with unrelated organizations. *Biloxi Regional Medical Center,* 835 F.2d at 350.

42 C.F.R. § 413.17 is a prophylactic rule barring the reimbursement of presumptively unreasonable costs. If, as alleged in the plaintiff's complaint, Alpha and the Superiors were related, then application of § 413.17 to the defendants is not in derogation of the Medicare program's main goal of delivering cost-efficient health care services to the needy. The potential over-inclusiveness or under-inclusiveness of § 413.17 as a prophylactic regulation does not affect its validity. *Shaker Medical Center,* 686 F.2d at 1209. The Secretary of HHS and HCFA need not promulgate regulations with exacting, mathematical precision. In a government program as complex and ripe with potential for abuse or fraud as Medicare, with its extremely large number of health care providers and their suppliers, the Secretary of HHS has broad discretion to promulgate reasonable regulations to control excessive costs through generalized classifications governing the methods of calculating reasonable costs. This is especially so when it is obvious that individualized cost calculations are unduly expensive and administratively impractical. The application of 42 C.F.R. § 413.17 as a prophylactic rule eliminates the need for a cumbersome, impractical, and very expensive administrative process of adjudicating the item-by-item reasonableness of all provider costs. *Biloxi Regional Medical Center,* 835 F.2d at 350; *Friedman,* 765 F.2d at 387; *University of Cincinnati,* 733 F.2d at 1176; *Shaker Medical*

Center, 686 F.2d at 1209; *Goleta Valley Community Hospital v. Schweiker,* 647 F.2d 894, 897 (9th Cir.1981); *Marina Mercy Hospital v. Harris,* 633 F.2d 1301, 1304 (9th Cir.1980); *Fairfax Hosp. Ass'n v. Califano,* 585 F.2d 602, 606 (4th Cir.1978).

With regard to reimbursement of costs to health care providers under the Medicare program where the provider and another related organization/supplier are involved in a transaction, the Secretary of HHS, acting through HCFA, has the authority to promulgate and enforce prophylactic regulations such as 42 C.F.R. § 413.17 which are broad in scope and designed to effectuate the purpose of the Medicare statutory scheme. *See Shaker Medical Center,* 686 F.2d at 1209. In short, HCFA's "related-party" regulations reasonably support and further the legitimate goal of avoiding payment of collusive and improperly inflated Medicare costs with a minimum of administrative burden. Reviewing the complaint in the light most favorable to the plaintiff under Rule 12(b)(6), the Court concludes that application of HCFA's related-party regulations to the defendants, including 42 C.F.R. § 413.17, is consistent with and not contrary to the fundamental purpose of the Medicare program.

*14 42 C.F.R. § 413.17 provides in part: "[c]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization." The regulation looks not to what the Superiors paid to Alpha for management services but rather looks to the cost to the related supplier, Alpha. *See Shaker Medical Center,* 686 F.2d at 1205. Medicare's PRM-1 § 1000 states that the purpose of the related-party rule is to avoid the payment of a profit factor to providers through their related organizations. When applying 42 C.F.R. § 413.17, it is immaterial whether the amount of management fees the Superiors paid to Alpha are reasonable and fair in comparison to the management fees usually charged by other unrelated organizations.

Accordingly, the defendants' Rule 12(b)(6) motion to dismiss the complaint [Court File Nos. 21, 26] is DENIED.

III. *Motions for Summary Judgment*

A. *Standard of Review*

FED. R. CIV. P. 56(c) provides that summary judgment will be rendered if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. The burden is on the moving party to conclusively show that no genuine issue of material fact exists, and the Court must view the facts and all inferences to be drawn therefrom in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 475, 587 (1986); *Morris v. Crete Carrier Corp.,* 105 F.3d 279, 280-81 (6th Cir.1997); *White v. Turfway Park Racing Ass'n, Inc.,* 909 F.2d 941, 943 (6th Cir.1990) ; *60 Ivy Street Corp. v. Alexander,* 822 F.2d 1432, 1435 (6th Cir.1987).

Once the moving party presents evidence sufficient to support a motion under Rule 56, the nonmoving party is not entitled to a trial merely on the basis of allegations. The nonmoving party is required to come forward with some significant probative evidence which makes it necessary to resolve the factual dispute at trial. *Celotex Corp. v. Catrett,* 477 U.S. 317 (1986); *White,* 909 F.2d at 943-44; *60 Ivy Street,* 822 F.2d at 1435. The moving party is entitled to summary judgment if the nonmoving party fails to make a sufficient showing on an essential element of the nonmoving party's case with respect to which the nonmoving party has the burden of proof. *Celotex,* 477 U.S. at 323; *Collyer v. Darling,* 98 F.3d 211, 220 (6th Cir.1996).

The judge's function at the point of summary judgment is limited to determining whether sufficient evidence has been presented to make the issue of fact a proper jury question, and not to weigh the evidence, judge the credibility of witnesses, and determine the truth of the matter. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 249 (1986); *60 Ivy Street,* 822 F.2d at 1435-36. The standard for summary judgment mirrors the standard for directed verdict. The Court must determine "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson,* 477 U.S. at 251-52; *see also Lapeer County, Mich. v. Montgomery County, Ohio,* 108 F.3d 74, 78 (6th

Cir.1997). There must be some probative evidence from which the jury could reasonably find for the nonmoving party. *Anderson,* 477 U.S. at 252; *Bailey v. Floyd County Bd. Of Educ.,* 106 F.3d 135, 140 (6th Cir.1997). If the Court concludes that a fair-minded jury could not return a verdict in favor of the nonmoving party based on the evidence presented, it may enter a summary judgment. *Anderson,* 477 U.S. at 251-52; *University of Cincinnati v. Arkwright Mut. Ins. Co.,* 51 F.3d 1277, 1280 (6th Cir.1995); *LaPointe v. UAW, Local 600,* 8 F.3d 376, 378 (6th Cir.1993).

B. Defendant's Motion Based on *Collateral Estoppel [Court File No. 111]*

***15** Defendants argue the complaint should be dismissed on the ground that the United States is precluded under the doctrine of collateral estoppel from litigating the critical issue of whether the Superiors and Alpha were "related" within the meaning of Medicare's rules and regulations during 1990-1993. After Charitable filed its cost reports with the FI seeking reimbursement for fiscal year 1987, FI Blue Cross and Blue Shield of South Carolina, made downward adjustments to those costs. On April 10, 1989, the FI issued a final determination known as a Notice of Program Reimbursement ("NPR") which reduced and disallowed a portion of the costs being claimed by Charitable for 1987. [Court File No. 112, Ex. A].

Charitable appealed the FI's adjustment and NPR to the PRRB. [Court File No. 112, Ex. B]. When the matter came before the PRRB, one of the theories advanced by the FI was that Charitable, then known as Superior Health Care of Chattanooga, and Alpha were related. [Court File No. 112, Ex. C, pp. 23-27]. The FI raised this issue in the context of whether it was proper for Charitable to pay Alpha 1.5% interest per month on all sums due to Alpha under their management agreement which had been outstanding for more than 30 days. To achieve a compromise on all disputes raised in the appeal to the PRRB, Charitable and the FI executed a comprehensive settlement agreement on April 30, 1991, captioned "STIPULATION OF ADMINISTRATIVE RESOLUTION." Paragraph 8 of the stipulation provides:

> The terms of this STIPULATION OF ADMINISTRATIVE RESOLUTION shall not be construed as an admission by the Provider that its reimbursement claims were unreasonable, or by the Intermediary that its adjustments were erroneous. This STIPULATION OF ADMINISTRATIVE RESOLUTION was negotiated as a compromise of good faith disputes. However, *with regard to the settlement of adjustment 4 (interest Expense), the Intermediary specifically withdraws its arguments that the interest at issue was incurred on a debt to a related party because the Intermediary did not find there was common ownership or control between the Provider and the management company.*

(Emphasis supplied).

An essential element of the plaintiff's complaint and theory of the case is that Charitable and Alpha were related parties during the period of time from January 1, 1990, through December 31, 1993. The complaint relies on alleged facts and circumstances as they existed on February 28, 1986, when Charitable first contracted with Alpha to provide management services. Defendants assert that the events relied on by the plaintiff to prove that Charitable and Alpha were related precede 1987. Defendants further argue that the stipulation executed by the FI concerning the 1987 cost reports collaterally estops the United States from now litigating the issue whether Charitable and Alpha were also related in 1990-1993. The defendants' premise is that if Charitable and Alpha were not related in 1987, then they likewise were not related in 1990- 1993.

***16** Defendants contend that the stipulation satisfies the prerequisites for collateral estoppel for the following reasons. The parties in the instant suit, the United States government and Charitable, are the same as those that litigated the related-party issue before the PRRB regarding Charitable's claims to be reimbursed for Medicare provider costs incurred in 1987. Defendants rely on the concept that fiscal intermediaries generally act as agents for, and their actions are imputed to, the Secretary of HHS. *Your Home Visiting Nurse v. Shalala,* 525 U.S. 449, 451 (1999) (FI acts as agent for Secretary of HHS); *Kraemer v. Heckler,* 737 F.2d 214, 215 (2nd Cir.1984); *Fox v. Bowen,* 656 F.Supp. 1236, 1238 (D.Conn.1987); 42 C.F.R. § 421.5(b). The Secretary of HHS has delegated administration of the Medicare program to HCFA. HCFA has in turn contracted with private insurance companies called fiscal intermediaries to handle claims processing, audit cost reports submitted by health care providers, and determine the proper amount of payments to participating providers of health care services rendered to Medicare beneficiaries. *Henry Ford Health System v. Shalala,* 233 F.3d 907, 908 (6th Cir.2000); 42 U.S.C. § 1395h;. According to the defendants, the parties had a full and fair opportunity to litigate the related-party issue in the PRRB proceeding and the stipulation evidences the parties' intent to be bound by their agreement on that issue for collateral estoppel purposes.

The Court concludes that the defendants' motion for summary judgment must be DENIED. The argument that collateral estoppel should be applied to the FI's stipulation is not persuasive.

The doctrine of collateral estoppel provides that once a court decides an issue of fact or law necessary to its judgment, the court's decision precludes the same parties and their privies from relitigating the same issue in another suit on a different cause of action. *Allen v. McCurry,* 449 U.S. 90, 94 (1980). When an issue is actually and necessarily determined by a court of competent jurisdiction, that determination is conclusive and cannot be disputed or litigated again in subsequent suits between the same parties. *Montana v. United States,* 440 U.S. 147, 153 (1979); *Aircraft Braking Sys. v. Local 856, UAW,* 97 F.3d 155, 161 (6th Cir.1996). Collateral estoppel relieves the parties of the vexation and expense of relitigating the identical issue in multiple lawsuits, conserves judicial resources, and encourages reliance on adjudications by preventing inconsistent decisions. *Allen,* 449 U .S. at 94; *Parklane Hosiery Co. v. Shore,* 439 U.S. 322, 326 (1979).

Collateral estoppel can also apply to those decisions of administrative agencies that have attained finality. When an administrative agency acting in a judicial capacity resolves disputed issues before it which the parties have had a fair opportunity to fully litigate, the doctrine of collateral estoppel may be applied to preclude further litigation on the same issue. *Astoria Federal Savings & Loan Ass'n v. Solimino,* 501 U.S. 104, 107-08 (1991); *Kremer v. Chemical Constr. Co.,* 456 U.S. 461, 485 n. 26 (1982); *University of Tennessee v. Elliott,* 478 U.S. 788, 798 (1986); *United States v. Utah Constr. & Mining Co.,* 384 U.S. 394, 422 (1966); *United States v. TDC Management Corp., Inc.,* 24 F.3d 292, 295-96 (D.C.Cir.1994); *see also, United States v. General Dynamics Corp.,* 828 F.2d 1356, 1361 (9th Cir.1987); *Paramount Transport Systems v. Chauffeurs, Teamsters & Helpers, Local 150, International Brotherhood of Teamsters,* 436 F.2d 1064 (9th Cir.1971).

***17** The Sixth Circuit has adopted a four-part test to determine whether collateral estoppel bars relitigation of an issue: (1) the precise issue raised in the present case must have been raised and actually litigated in the prior proceeding; (2) judicial determination of the issue must have been necessary to the outcome of the prior proceeding; (3) the prior proceeding must have resulted in a final judgment on the merits; and (4) the party against whom estoppel is sought must have had a full and fair opportunity to litigate the issue in the prior proceeding. *Smith v. S.E.C.,* 129 F.3d 356, 362 (6th Cir.1997); *Bills v. Aseltine,* 52 F.3d 596, 604 (6th Cir.1995); *Central Transport, Inc. v. Four Phase Systems, Inc.,* 936 F.2d 256, 259 (6th Cir.1990); *Detroit Police Officers Ass'n v. Young,* 824 F.2d 512, 515 (6th Cir.1987).

The defendants' motion is DENIED for the following reasons. The Secretary of HHS is not bound by the stipulation entered into by the FI at the PRRB proceeding. Pursuant to 42 C.F.R. § 405.1843, the Secretary of HHS and HCFA were not parties to and did not participate in the PRRB proceeding. The Court will not hold HHS and HCFA responsible for a stipulation they had no chance to challenge and that may conflict with HCFA's official position. *Howard Young Medical Center, Inc. v. Shalala,* 207 F.3d 437, 443 (7th Cir.2000).

In the alternative, assuming *arguendo* that HCFA is bound by the FI's stipulation predicated on the theory that the FI executed the stipulation as an agent for the Secretary of HHS, the motion for summary judgment must be DENIED because there are genuine issues of material fact in dispute whether the defendants made false representations to the FI which fraudulently induced the FI to enter into the stipulation. If the FI was fraudulently induced to agree to the stipulation as a result of the defendants making misrepresentations of fact on the related-party issue, then the stipulation is void *ab initio* and cannot be enforced under the doctrine of collateral estoppel. In ruling on the defendants' summary judgment motion, the Court views the record in the light most favorable to the plaintiff with regard to whether the stipulation null and void due to fraudulent inducement.

Furthermore, the doctrine of collateral estoppel only applies if an issue of fact or law has been actually litigated and determined by a final judgment. When Charitable and the FI negotiated a compromise and executed the stipulation, they did not actually litigate the related-party issue to a final decision by the PRRB. Their stipulation of administrative resolution is essentially the same as a consent judgment. In cases involving consent judgments, the issues are not actually litigated for purposes of collateral estoppel. Consent judgments and compromise settlements ordinarily occasion no collateral estoppel unless it is manifestly clear that the parties intend for their settlement agreement to have the effect of precluding further litigation on specific issues. *Arizona v. California,* 530 U.S. 392, 414 (2000); *United States v. International Building Co.,* 345 U.S. 502 (1953); *Foster v. Hallco Mfg. Co.,* 947 F.2d 469, 480-82 (Fed.Cir.1991); *Masters v. Crouch,* 872 F.2d 1248, 1255-56 (6th Cir.1989); *Klingman v. Levinson,* 831 F.2d 1292, 1295-96 (7th Cir.1987); *Balbirer v. Austin,* 790 F.2d 1524, 1527-28 (11th Cir.1986); *Southern Pacific Com. v. American Tel. & Tel. Co.,* 740 F.2d 1011, 1021 (D.C.Cir.1984); *Red Lake Band v. United States,* 607 F.2d 930, 934, 221 Ct. Cl. 325 (1979); *Green v. Ancora-Citronelle Corp.,* 577 F.2d 1380, 1383 (9th Cir.1978) (collateral estoppel applied to stipulation where court determined that parties intended to adjudicate once and for all the issues raised); *Kaspar Wire Works, Inc. v. Leco Engineering & Mach.,* 575 F.2d 530, 537-42 (5th Cir.1978).

***18** In *Masters,* 872 F.2d at 1255-56, the Sixth Circuit observed that federal courts move very cautiously when asked to apply the doctrine of collateral estoppel and give issue-preclusive effect to consent judgments. Where one party contends that a consent judgment precludes all future litigation of an issue, the language used by the parties in the consent decree must be narrowly construed and such an intention should not readily be inferred. *Foster,* 947 F.2d at 481.

The plain language in the stipulation between Charitable and the FI does not evidence a clear, unambiguous intent by them to completely preclude any and all future litigation on the related-party issue. Such an intent cannot be reasonably inferred from the stipulation. The Court does not construe the stipulation as establishing that the parties had a clear intent to be forever bound on the related-party issue sufficient to trigger application of the collateral estoppel doctrine. Instead, the Court interprets the stipulation as meaning that the parties intended only to achieve a limited settlement of Charitable's claim seeking reimbursement for Medicare provider costs incurred in 1987. The stipulation has a claim-preclusive effect for fiscal year 1987 but there is no issue preclusion or collateral estoppel with regard to the issue whether Charitable and Alpha were related to each other in 1990-1993. *See Arizona,* 530 U.S. at 414. Consent judgments ordinarily are designed and intended to bar further litigation on the claims presented but are not intended to preclude future litigation on any issues presented. Thus, consent judgments usually support claim preclusion but not issue preclusion under principles of collateral estoppel. *Id.;* 18 CHARLES ALAN WRIGHT, ARTHUR R. MILLER & EDWARD H. COOPER, FEDERAL PRACTICE AND PROCEDURE: JURISDICTION § 4443, pp. 384-85 (1981).

Accordingly, the defendants' motion [Court File No. 111] is DENIED. The Court will not apply the doctrine of collateral estoppel to the stipulation.

C. Defendant's Motion Based On HCFA's Decision Not To Reopen The Fiscal Intermediary's Prior Determinations Under 42 C.F.R. § 405.1885(d) *[Court File No. 185]*

Defendants next move for summary judgment on the ground that HCFA has decided not to reopen the FI's final reimbursement determinations or NPRs for fiscal years 1990-1993 under 42 C.F.R. § 405.1885(d) after this Court referred the related-party issue to HCFA. On April 12, 1999, the Court invoked the doctrine of primary jurisdiction and referred to HCFA and HHS the issue of whether the various Superior Home Health Care entities were related to Alpha and William Rogers. [Court File Nos. 115, 116]. HCFA decided not to reopen and consider the related-party issue even though it has the authority to do so pursuant to 42

C.F.R. § 405.1885(d). Section 405.1885(d) provides that a FI's determination or hearing decision, a PRRB decision, or a decision of the HHS Secretary "shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision."

***19** On June 26, 2000, a HCFA official, Thomas Hoyer in his capacity as Director of the Chronic Care Policy Group at the Center for Health Plans and Providers, wrote a letter to the FI, Palmetto Government Benefits Administrators, LLC, ("Palmetto") in Columbia, South Carolina. Palmetto is a wholly owned subsidiary of Blue Cross and Blue Shield of South Carolina. In his letter to FI Palmetto [Court File No. 173, Plaintiff's Status Report], Thomas Hoyer states in pertinent part: "HCFA has determined that it should decline to consider the related-party issue. We are therefore instructing Palmetto not to reopen the cost reports of the providers involved in [the FCA lawsuit] for this purpose." HCFA declined to have FI Palmetto reopen the Superiors' cost reports for 1990-1993 pursuant to 42 C.F.R. 405.1885(d) to determine whether Alpha and the Superiors were related.

On June 28, 2000, Sheree Kanner, Chief Counsel in HCFA's Office of General Counsel, forwarded a copy of Thomas Hoyer's letter to the United States Department of Justice. In her accompanying cover letter [Court File No. 173], Kanner explains HCFA has determined that it should decline to consider the related-party issue, as HCFA continues to believe that in the context of a FCA case, the federal district court is the correct forum for determination of this issue.

1. Have FI and HCFA Determined the Issue of Whether There Was Fraud or *Similar Fault Committed by Defendants?*

Defendants argue they are entitled to summary judgment for two reasons. First, defendants say that HCFA's decision to instruct FI Palmetto not to reopen the FI's final determinations and NPRs on the Superiors for 1990-1993 pursuant to 42 C.F.R. § 405.1885(d) necessarily means HCFA has concluded that the FI's determinations were not procured through fraud or other similar fault by the defendants. Defendants reason that had HCFA found otherwise, then 42 C.F.R. § 405.1885(d) makes it mandatory that the FI's determinations shall be reopened and revised. It is argued that since HCFA has decided not to reopen, the government's allegations against the defendants in the present complaint must have made no difference to the FI's determinations to approve the payment of Superiors' claims for the reimbursement of management costs concerning Alpha for 1990-1993.

This argument is not persuasive. The reason HCFA now declines to consider the related-party issue and the reason why HCFA is not reopening the FI's determinations is that HCFA believes this Court is the more appropriate forum to adjudicate the issue in the context of a FCA suit. HCFA's position in response to the Court's referral under the primary jurisdiction doctrine does not, as the defendants suggest, necessarily mean HCFA has concluded that the FI's determinations were not procured through fraud or other similar fault on the defendants' part. On the contrary, HCFA defers to the Court with regard to ruling on the related-party issue. HCFA has chosen not to address the related-party issue at this time. HCFA's instructions to FI Palmetto not to reopen the FI determinations for 1990-1993 do not amount to a final administrative decision by HCFA to the effect that the defendants did not procure the FI's determinations through fraud or other similar fault. In addition, plaintiff has submitted proof showing that FI Palmetto did not actually consider and determine the related-party issue and the controversy surrounding the false bid letters in deference to an ongoing investigation by the HHS Office of Inspector General ("OIG"), discussed *infra.* [Court File Nos. 215, 218].

***20** As the Court explains in its opinion rendered on April 12, 1999 [Court File No. 115, pp. 14-15, 27-28], when the related-party issue is "referred" to HCFA under the primary jurisdiction doctrine, this Court does not have the authority to order or require HCFA to determine the issue. The Court stayed these judicial proceedings to afford the parties an opportunity to apply to HCFA for a definitive administrative ruling in accordance with the usual, established administrative regulations and procedures. *Reiter v. Cooper,* 507 U.S. 258, 268 n. 3 (1993); *United States v. Haun,* 124 F.3d 745, 740 (6th Cir.1997). The primary jurisdiction doctrine merely enables federal courts to stay judicial proceedings while seeking the guidance of an administrative agency's expertise. When the HCFA declines to provide guidance or to commence administrative proceedings which might obviate the need for judicial action, then this Courts can and should proceed to exercise its jurisdiction to adjudicate the issue. *Owner-Operator Independent Drivers v. New Prime,* 192 F.3d 778, 785-86 (8th Cir.1999).

Because HCFA declines to reopen the FI's determinations to make a ruling on the related-party issue, the Court must now proceed to exercise its jurisdiction to adjudicate the government's complaint brought pursuant to the FCA and common law. Absent a compelling and legitimate reason to the contrary, this Court has a "virtually unflagging obligation" to exercise the subject matter jurisdiction granted to it. *Colorado River Water Conservation Dist. v. United States,* 424 U.S. 800, 817-18 (1976); *see also McCarthy v. Madigan,* 503 U.S. 140, 146 (1992); *Haun,* 124 F.3d at 752. The Court may not abdicate its duty to exercise its subject matter jurisdiction merely because the plaintiff's action sounds in administrative law. *Id.*

Although 42 C.F.R. § 405.1885(d) provides that the determination of a FI shall be reopened and revised if it is established that such determination was procured by fraud or similar fault of any party to the determination, § 405.1885(d) does not require HCFA to immediately reopen the FI's determinations as a result of the Court's referral of the related-party issue to HCFA under the primary jurisdiction doctrine. Section 405.1885(d) provides that determinations of a FI can be reopened and revised "at any time." The plain language of § 405.1885(d) does not make it mandatory that HCFA must reopen the FI's determinations before the Court adjudicates the government's FCA and common law claims against the defendants.

Moreover, 42 C.F.R. § 405.1885(d) does not explain or designate precisely who must "establish" that the FI's determination has been procured through fraud or similar fault by a party. Instead of reopening the FI's determinations or NPRs at this time to render an administrative ruling on the related-party issue, HCFA has chosen to leave the issue to be litigated and decided by the Court in the context of the FCA suit. HCFA in effect wants the Court to determine whether the FI's determinations were procured by fraud or similar fault. HCFA's position is not inconsistent with § 405.1885(d).

***21** By invoking the primary jurisdiction doctrine, the Court has afforded HCFA and HHS with a fair opportunity to initially address and make an administrative ruling on the related-party issue. HCFA could have utilized § 405.1885(d) to reopen the FI's determinations to allow HCFA to interpret, apply, and enforce its own Medicare administrative regulations. This would have served the salutary purpose of promoting consistency and uniformity in the interpretation and application of Medicare regulations, but HCFA declines to take further action at this time..

2. Have FI and HCFA Made a Final Administrative Decision on the Related-Party Issue that is Binding *Upon the Plaintiff and this Court?*

The defendants' second argument is that HCFA's decision to not reopen has the effect of reaffirming the FI's earlier determinations (NPRs) wherein the FI, after auditing the Superiors' costs reports for 1990-1993, concluded that Alpha's management fees were fully reimbursable to the Superiors under Medicare rules and regulations. Defendants contend that when the FI audited the cost reports submitted by the Superiors for 1990-1993, the FI necessarily reviewed whether Alpha was related to the Superiors. Defendants assert that when HCFA instructs FI Palmetto to not reopen the FI's determinations and consider the related-party issue pursuant to 42 C .F.R. § 405.1885(d) after the matter has been referred to HCFA by the Court under the primary jurisdiction doctrine, the net result is to leave in place the FI's determinations (NPRs) as being the final, official administrative decisions which are binding on HCFA. There exist formal administrative and appellate procedures to challenge and revise the FI's determinations which HCFA has decided not to use. Consequently, defendants argue that the government cannot now collaterally attack the FI's final determinations in this Court by bringing an action under the FCA.

Defendants also point out that in 1996 when FI Palmetto was conducting some of the audits at issue, FI Palmetto knew that the United States Department of Justice was alleging that the defendants had engaged in fraud in connection with the related-party determination. In 1996, FI Palmetto received a copy of an criminal indictment that had been returned by a federal grand jury against defendant Callaway, the former executive director of Superior Home Health Care of Chattanooga. The indictment charged that the defendants had created fraudulent documents, *i.e.*, the false bid letters, in an attempt to falsely show that the selection of Alpha as the Superiors' management company was an arms length transaction and the result of a fair, open bidding process among competing management companies. Two months after receiving the indictment and with full knowledge of the federal government's allegations about the false bid letters, FI Palmetto went ahead and approved the reimbursement of the full cost of Alpha's management fees to the Superiors as being in compliance with Medicare regulations.

***22** Defendants rely on the following legal theories. When a federal court invokes the primary jurisdiction doctrine and refers a specific issue of fact or law to an administrative agency, the referring court is bound by that agency's final decision on the issue and the referring court cannot collaterally review the merits of the agency's decision. *Port of Boston Marine Terminal Ass'n v. Rederiaktiebolaget Transatlantic,* 400 U.S. 62 (1970); *General Dynamics,* 828 F.2d at 1360; *Locust Cartage Co. v. Transamerican Freight Lines, Inc.,* 430 F.2d 334, 341 (1st Cir.1970). Defendants also argue that beyond the doctrine of primary jurisdiction, the Medicare Act itself prohibits this Court from collaterally reviewing HCFA's final administrative decisions. Defendants cite *Heckler v. Ringer,* 466 U.S. 602 (1984) for the proposition that the Medicare Act does not permit federal courts to exercise original federal-question jurisdiction pursuant to 28 U.S.C. § 1331, outside of established agency procedures, to collaterally adjudicate claims that "arise under" the Medicare Act. *See also Shalala v. Illinois Council,* 529 U.S. 1 (2000); *Your Home Visiting Nurse,* 525 U.S. at 456; *Weinberger v. Salfi,* 422 U.S. 749 (1975); *Buchanan v. Apfel,* 249 F.3d 485, 488-89 (6th Cir.2001); 42 U.S.C. §§ 405(h) and 1395ii.

These arguments fail. This Court will not grant summary judgment to the defendants because there are genuine issues of material fact in dispute whether the FI actually reviewed the related-party issue and made a final determination that the Superiors were not related to Alpha and William Rogers during 1990- 1993. In ruling on the defendants' summary judgment motion, the Court is required to review the record in the light most favorable to the plaintiff. Plaintiff has come forward with proof showing there is a factual dispute about whether FI Palmetto reviewed and made a final determination on the issue of whether the Superiors were related to Alpha and William Rogers during fiscal years 1990-1993. [Court File No. 215 pp. 5-6, and Court File No. 218]. When FI Palmetto audited the Superiors' cost reports for 1990-1993, the FI was aware there existed allegations of fraud against the defendants concerning the false bid letters that were the subject of an ongoing investigation by the HHS OIG. The FI declined to consider the related-party issue and the impact of the alleged false bid letters in deference to the OIG investigation. [Court File No. 218, Exhibit X, declaration of James Peebles]. Based on the proof submitted by the plaintiff, the Court cannot find it is undisputed that the FI and HCFA made a final, binding administrative decision on the related-party issue. Viewing the record in the light most favorable to the plaintiff, it appears that the related-party issue has not been actually litigated by the parties and finally adjudicated on the merits by FI Palmetto, the PRRB, and HCFA.

The plaintiff's explanation about FI Palmetto deferring to the OIG on the related-party issue and deferring to the OIG investigation of alleged fraud involving the false bid letters makes good, practical sense. Under the Inspector General Act of 1978, 5 U.S.C. Appendix 3, each Inspector General reports to and is under the general supervision of the head of the agency. 5 U.S.C.App. 3 § 3(a). The OIG of HHS is under the general supervision of the Secretary of HHS. The OIG is authorized to conduct, supervise, and coordinate audits and investigations relating to the programs and operations of HHS. 5 U.S.C.App. 3 § 4(a)(1). If as a result of an audit or investigation the OIG has reasonable grounds to believe that there has been a violation of federal criminal law, the OIG must expeditiously report such information to the Attorney General of the United States. 5 U.S.C.App. 3 § 4(d). The United States Department of Justice may then bring criminal charges and, if necessary, institute a civil action against the wrongdoer pursuant to the FCA. *Association of American Medical Colleges v. United States,* 217 F.3d 770, 779 n. 6 (9th Cir.2000). Within the Medicare regulatory scheme, HCFA and the FI are not primarily responsible for investigating and prosecuting fraud committed against the Medicare program. The HHS OIG has primary responsibility for investigating Medicare fraud. Timothy Stolzfus Jost, *Recent Developments Health Care Symposium: Governing Medicare,* 51 ADMIN. L. REV. 39, 83-84 (1999).

***23** In reply [Court File No. 227], defendants say the plaintiff's proof, especially the declaration of James Peebles, cannot create a genuine dispute of material fact which precludes summary judgment because the proof is contrary to the contemporaneous evidence. Defendants assert the plaintiff's position that FI Palmetto did not consider the related-party issue is contradicted by oral statements made by the FI's representatives when the NPRs were issued. Defendants refer to the transcript of an exit conference held by the FI's representatives on January 16, 1996, concerning Superior Home Health Care of Middle Tennessee. During this exit conference, representatives of FI Palmetto said they did not have a question about whether Superior Home Health Care of Middle Tennessee was related to Alpha. But the FI's representative also commented there was an ongoing OIG investigation and the OIG might make some other determination. This was an indication the by FI Palmetto that it was deferring to the OIG investigation on the related-party issue and alleged fraud.

Defendants contend that the plaintiff's position is inconsistent with the unconditional, unqualified approval expressed by FI Palmetto in the NPRs approving reimbursement to the Superiors for the full cost of Alpha's management fees. In the NPRs, FI Palmetto did not express reservations about the criminal indictment against Callaway and an ongoing OIG investigation into allegations of fraud regarding the false bid letters. The NPRs do not explicitly state or indicate that the FI was declining to review and make a determination on the related-party issue. Defendants want the Court to infer from this that the related-party issue was actually reviewed and finally determined by FI Palmetto.

These arguments are not persuasive. Reviewing the record in the light most favorable to the plaintiff, there are genuine issues of material fact in dispute about whether the FI actually considered and finally determined the issue whether the Superiors were related to Alpha and William Rogers. In retrospect, FI Palmetto may have exercised poor judgment when it chose to go ahead and approve the reimbursement of Alpha's management fees to the Superiors for 1990-1993 even though FI Palmetto was aware of the indictment against Callaway and the pending OIG investigation into allegations of fraud which could have a significant impact on whether the Superiors were related to Alpha. It would have been better if FI Palmetto had either delayed issuing the NPRs until after the OIG investigation was completed or, in the alternative, expressly stated in the NPRs that FI Palmetto was not making a determination on the related-party issue. But such conduct by the FI is understandable since the FI was operating on the belief that it was the OIG's responsibility to investigate whether there was Medicare fraud committed by the Superiors and that the FI's determinations could later be reopened and revised at any time under 42 C.F.R. § 405.1885(d) if it was established that the FI's determinations had been procured by fraud on the part of the Superiors.

***24** The defendants' reliance on *Ringer,* 466 U.S. 602, is misplaced. The Supreme Court has held that judicial review of findings and administrative decisions by the HHS Secretary under the federal-question jurisdiction statute, 28 U.S.C. § 1331, is generally precluded by 42 U.S.C. § 405(h) which is made applicable to the Medicare Act by operation of 42 U.S.C. § 1395ii. *Your Visiting Home,* 525 U.S. at 456; *Ringer,* 466 U.S. at 615; *Ohio Hosp. Ass'n v. Shalala,* 201 F.3d 418, 422-23 (6th Cir.1999). When 42 U.S.C. §§ 405(h) and 1395ii are read together, they provide that the findings and decisions of the HHS Secretary after a hearing shall be binding on all parties to the hearing. No findings of fact or decision of the HHS Secretary shall be reviewed by any person, tribunal, or government agency except as provided in the Medicare Act. No action against the United States, the HHS Secretary, or any officer or employee of HHS shall be brought under 28 U.S.C. §§ 1331 or 1346 to recover on any claim "arising under" the Medicare Act.

42 U.S.C. § 405(h) is intended to prevent Medicare beneficiaries from circumventing the administrative process established to adjudicate disputes between them and the federal government involving claims for Medicare benefits. Section 405(h) takes away

general federal-question jurisdiction over claims by Medicare beneficiaries thereby forcing them to pursue their claims through the administrative process and then, if necessary, in an appeal for judicial review under the specific grant of jurisdiction to federal courts contained in 42 U.S.C. § 405(g). The third sentence in § 405(h) is the final piece in an administrative scheme designed to give the administrative process the first opportunity to resolve disputes over eligibility or the amount of benefits awarded pursuant to the Medicare Act. *Ohio Hosp. Ass'n,* 201 F.3d at 424; *United States ex rel. Body v. Blue Cross and Blue Shield of Alabama, Inc.,* 156 F.3d 1098, 1103-04 (11th Cir.1998). Nothing in § 405(h) suggests that it eliminates federal-question jurisdiction (28 U.S.C. § 1331) over all other actions implicating the Medicare Act, regardless of the availability or unavailability of administrative review and judicial review within the Medicare administrative scheme. *Id.*

Ringer and its progeny do not bar the United States government from maintaining the instant suit in federal court against the defendants under the False Claims Act and common law. The FCA and the common law provide a separate, independent basis for this Court to exercise subject matter jurisdiction over the government's claims. In *Shalala v. Illinois Council,* 529 U.S. at 12, the Supreme Court explains that 42 U.S.C. § 405(h) applies where both the standing and the substantive basis for the presentation of the plaintiff's claim is the Medicare Act. *See Ringer,* 466 U.S. at 615. In the case at bar, the federal government's standing to bring this action and the substantive basis for its claims are the FCA and common law, not the Medicare Act. See *Body,* 156 F.3d at 1105-06. The instant case is readily distinguishable from *Heckler.* In *Heckler,* individual Medicare claimants filed suit in federal district court challenging certain adverse administrative decisions and policies of the HHS Secretary denying them reimbursement of medical expenses. In an unsuccessful effort to establish subject matter jurisdiction in federal district court, the plaintiffs in *Heckler* relied on 28 U.S.C. § 1331 and 28 U.S.C. § 1361 (mandamus against federal official). *Heckler,* 466 U.S. at 609. In the instant case, plaintiff United States is not in the same position as a disgruntled Medicare beneficiary who seeks to challenge an adverse administrative decision by the Secretary of HHS denying a claim for Medicare benefits. Instead, the government brings this action pursuant to the FCA and common law to recover monies that are alleged to have been wrongfully paid by HCFA as a result of the defendants' false claims and/or fraud. 42 U.S.C. §§ 405(h) and 1395ii do not preclude the United States from bringing an independent action in federal district court to litigate these claims under the FCA and common law. *See United States ex rel. Rahman v. Oncology Associates,* P.C., 198 F.3d 502, 513 (4th Cir.1999).

***25** In *Body,* 156 F.3d 1098, the Eleventh Circuit held that a qui tam action brought under the FCA alleging Medicare fraud was not an action "arising under" the Medicare Act and it was not barred by 42 U.S.C. § 405(h). Actions which do not seek payment from the government and cannot not be brought under the statute governing the administrative and judicial review of decisions on claims by Medicare beneficiaries, 42 U.S.C. § 405, are not barred by 42 U.S.C. § 405(h) which revokes federal-question jurisdiction in the federal district courts over cases "arising under" the Medicare Act. The *Body* Court reasoned that although application of Medicare rules and regulations are determinative of whether false claims were in fact submitted, the complaint premised upon the defendant's knowing submission of false and fraudulent claims to the government was authorized by the FCA, not the Medicare Act. *Id.* at 1105-06.

The same rationale from *Body* applies in the case at bar. To determine whether the defendants submitted false and fraudulent claims to the FI and HCFA, this Court must necessarily look to and apply HCFA's rules and regulations governing the reimbursement of costs to Medicare providers. This does not, however, mean that this suit being brought pursuant to the FCA and common law is a case "arising under" the Medicare Act for purposes of enforcing 42 U.S.C. § 405(h). On the contrary, the jurisdictional bar in § 405(h) does not apply to an action filed by the United States government under the FCA and common law alleging that a fraud has been perpetrated against the government and seeking to recover damages and restitution to be paid to the government.

The defendants' motion is DENIED.

D. Defendants' Motion and the "Once Related, Always Related" Rule in *PRM-1 1011.2 [Court File No. 108]*

Defendants in this motion seek to either dismiss the complaint under FED. R. CIV. P. 12(b)(6) or, in the alternative, move for summary judgment. Because the parties have submitted and the Court has taken into consideration various documents, affidavits, and depositions outside the complaint, the Court will treat the motion as one for summary judgment pursuant to FED. R. CIV. P. 56. The motion is DENIED. There are genuine issues of material fact in dispute which preclude summary judgment.

The primary issue in dispute is whether Alpha and its owner, William Rogers, had control over the Superiors within the meaning of 42 C.F.R. § 413.17(b) thereby making Alpha related to the Superiors. The term "control" is broadly defined. 42 C.F.R. § 413.17(b)(3) provides: "Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." PRM-1 § 1004.3 provides that the control "includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise." After reviewing the record in the light most favorable to the plaintiff, the Court concludes there is a genuine factual dispute regarding the issue of control which must be resolved at trial.

***26** A key argument raised by the defendants concerns what is the correct application of HCFA's "once related, always related" rule. PRM-1 § 1011.2 provides: "If a [Medicare] provider and a supplier are related by common ownership or control at the time of executing a supply contract, the provider's allowable costs will be governed by the related organization principle throughout the full term of the supply contract, even if the common ownership or control terminates before the end of the contract." Defendants argue that § 1011.2 is not applicable to the contractual relationship that existed between Alpha and Charitable for fiscal years 1990-1993. Defendants contend that even if we assume for the sake of discussion that Alpha and William Rogers were related to Charitable/Superior Home Health Care of Chattanooga in 1986, they were not related in 1990-1993 because different contracts were in force in 1990-1993. More precisely, defendants say that the initial contract between Charitable and Alpha was executed in 1986 and expired at the end of 1988. Charitable and Alpha executed a new management contract that ran from January 1, 1989, through December 31, 1991. When this contract expired, Charitable and Alpha executed another management contract covering the period of time from January 1, 1992, through December 31, 1994.

The United States contends the "once related, always related" rule in PRM-1 § 1011.2 is applicable because the management contracts between Alpha and Charitable in 1989-1994 were merely a continuation of their same initial contract executed in 1986. The terms of the management contracts remained virtually identical throughout the entire history of Alpha's contractual relationship with Charitable. Plaintiff asserts that the defendants are not entitled to summary judgment because they have not produced any evidence to show that William Rogers alleged control over Charitable ended before the latter two management contracts were executed with Alpha in 1989 and 1992. Plaintiff argues that the defendants have not presented proof which establishes it is an undisputed fact that William Rogers and Alpha no longer controlled Charitable and the Superiors in 1999-1993 or that Alpha's contractual relationship with Charitable materially changed from 1986 through 1993.

Plaintiff submits the sworn declaration of their HCFA expert witness, Bruce Robert Oliver. [Court File No. 208]. According to Oliver, the "once related, always related" rule is a prophylactic regulation which is applied by HCFA to situations involving successive contracts between a Medicare provider and a supplier. Oliver states that where contract terms and conditions have not been changed materially or undergone truly arms-length renegotiation, the contracting parties have not changed, and the Medicare provider has not otherwise broken the chain of relatedness by submitting the contract to a legitimate competitive bidding process involving other potential, competent suppliers of service, then HCFA is of the view that subsequent contracts between a provider and related supplier are no more than mere extensions of the initial supply contract. Oliver says that HCFA emphasizes substance over form, and

HCFA would continue to apply PRM-1 § 1011.2 to such successive contracts.

***27** Based on these factors and Oliver's expert opinion, the Court will not grant summary judgment to the defendants on their theory that the "once related, always related rule" is not applicable to the management contracts between Alpha and Charitable during 1989-1994. The material facts are in dispute and the Court cannot, at this time, determine whether PRM-1 § 1011.2 is applicable in this case. The factual issues surrounding the correct application of PRM-1 § 1011.2 to Charitable's contracts with Alpha will have to be resolved at trial. For example, defendants allege that subsequent to 1987, Charitable did go through a legitimate competitive bidding process where it solicited and obtained bids from other organizations to furnish it with management services before Charitable ultimately decided to renew its contracts with Alpha. If the defendants are able to produce such evidence at trial, it may be sufficient to "break the chain" of relatedness and show that PRM-1 § 1011.2 should not be applied to Alpha and Charitable. This remains to be determined at trial. Accordingly, the defendants' summary judgment motion [Court File No. 108] is DENIED.

E. Defendants' Motion for Partial Summary Judgment Declaring that PRM-1 § 1011.2 *Does Not Apply [Court File No. 105]*

Defendants' move for partial summary judgment and ask the Court to declare that the "once related, always related" rule in PRM-1 § 1011.2 is not applicable in this case. The Court has already discussed this same issue *supra*. The motion is DENIED. Viewing the record in the light most favorable to the plaintiff, there are genuine issues of material fact in dispute which preclude summary judgment. Summary judgment is inappropriate because the Court is unable to determine from the disputed facts whether PRM-1 § 1011.2 can or should be applied to the contracts that existed between Alpha and the Superiors in 1990- 1993. The Court needs to hear more proof on the issue including the testimony of expert witnesses such as Bruce Robert Oliver who is an expert on the interpretation and application of HCFA's rules and regulations.

F. Defendants' Motion for Partial Summary Judgment on the False *Bid Letters [Court File No. 187]*

Defendants move for partial summary judgment on part of the claims in Counts II and IV of the complaint concerning whether the false bid letters constitute actionable false statements under the FCA, 31 U.S.C. § 3729(a)(2) and (7). Defendants contend the false bid letters relate to the period of time in 1986 when the relationship between Alpha and Superior Home Health Care of Chattanooga was initially formed. The false bid letters were only submitted to the FI in 1988 with regard to cost reports for fiscal year 1986, and also submitted to the PRRB in 1990 in connection with the review of cost reports for fiscal year 1987. However, the cost reports for fiscal years 1986 and 1987 are not at issue in this suit. The plaintiff's amended complaint seeks to recover money that HCFA paid out to the Superiors concerning cost reports submitted for fiscal years 1990-1993. Any potential FCA claims seeking to recover money that the government paid out to the Superiors with regard to their cost reports for fiscal years 1986-1987 are time-barred by the statute of limitations.

***28** Defendants argue there is no proof that they submitted the false bid letters to the FI, PRRB, and HCFA in connection with the cost reports for fiscal years 1990-1993. Moreover, defendants say there is no proof that the FI ever considered and relied on the false bid letters when the FI reviewed and made decisions on the 1990-1993 cost reports. Defendants move for partial summary judgment for two reasons: (1) the plaintiff cannot sustain its burden of proof to prove that the false bid letters were material to the FI's determinations to reimburse Superior Home Health Care of Chattanooga for Alpha's management fees for fiscal years 1990-1993; and (2) any claims by the plaintiff based on the submission of the false bid letters to the FI in 1988 and 1990, more than six years prior to the filing of the plaintiff's complaint in this action, are time-barred by the statute of limitations.

The defendants' motion for partial summary judgment is GRANTED pursuant to FED. R. CIV. P. 56 for the following reason. In Counts II and IV of the complaint, plaintiff avers that the defendants made, used, or caused to be made and used, the false bid letters to get false and fraudulent claims paid by the government in violation of the FCA.

The false claims in question concern the Superiors' claims that they were entitled to reimbursement from the Medicare program for Alpha's management fees in fiscal years 1990-1993. However, there is no proof in the record that the defendants used, caused to be used, or submitted the false bid letters to the FI, PRRB, or HCFA in an effort to obtain the reimbursement of Alpha's management fees for fiscal years 1990-1993. There is no genuine issue of material fact in dispute and the defendants are entitled to summary judgment. To the limited extent that the government claims in Counts II and IV that the false bid letters are actionable false statements under the FCA with regard to fiscal years 1990-1993. said claims are DISMISSED.

The government may proceed to trial on the remainder of Counts II and IV of its complaint which allege that the defendants made or used other false statements and false records, *i.e.,* the 1990-1993 cost reports and provider questionnaires. Although the false bid letters are not actionable false statements under the FCA with regard to fiscal years 1990-1993, nevertheless, the false bid letters can be introduced as evidence at trial concerning the issue of scienter and whether the defendants acted knowingly in violation of the FCA.

G. Plaintiff's Motion for Partial *Summary Judgment [Court File No. 35]*

Plaintiff moves for partial summary judgment on the issue whether Alpha was related to Superior Home Health Care of Livingston, Inc. ("SHHC-L") and Superior Home Health Care of East Tennessee, Inc. (SHHC-ET") within the meaning of HCFA's rules and regulations. Plaintiff contends that SHHC-L was owned by Robert Lee ("Lee") from 1986-1992, and SHHC-ET was owned by Stephen McDonough ("McDonough") from 1986 through at least 1994. Lee and McDonough were brothers-in-law of Gayle Rogers during the time that Alpha managed SHHC-L and SHHC-ET. Lee and McDonough were married to Gayle Rogers' sisters. William Rogers, the sole owner of Alpha, was married to Gayle Rogers. Gayle Rogers was an officer and director of Alpha through at least January 1988.

***29** Based on these facts, plaintiff argues there is an irrebuttable presumption that Alpha was related to SHHC-L and SHHC-ET. Plaintiff relies on PRM-1 § 1004 which provides in relevant part: "The existence of an immediate family relationship will create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests .... The following person are considered immediate family for Medicare program purposes ... sister-in-law, brother-in-law ...." Furthermore, plaintiff asserts that William Rogers' ownership interest in Alpha is attributable to his wife, Gayle Rogers, for the purpose of determining whether Gayle Rogers possessed a significant ownership interest in Alpha. PRM-1 at § 1004.2 sets forth examples of common ownership. It states the following example of the concept of attribution of ownership between married persons in Example No. 3:

> Mr. L owns 20 percent of the outstanding shares of a corporate provider and a 50 percent interest in the supporting organization, a partnership. Ms. L., Mr. L's spouse, owns 30 percent of the outstanding shares of the provider corporation. Because Mr. and Ms. L cumulatively hold 50 percent of the provider and Mr. L owns 50 percent of the supplier, the organizations are considered related by common ownership.

Under these HCFA rules contained in the PRM, plaintiff says there exists an irrebuttable presumption that Alpha was related to SHHC-L and SHHC-ET by common ownership and/or control because Gayle Rogers was a sister-in-law of the owners of SHHC-L and SHHC-ET. Plaintiff contends that Gayle Rogers was an officer and director of Alpha at least up through January 1988, and William Rogers' ownership interest in Alpha is attributable to Gayle Rogers as a result of their marriage. Plaintiff moves the Court to grant it partial summary judgment and determine as a matter of law that Alpha was related to SHHC-L and SHHC-ET.

The plaintiff's motion is GRANTED. The Court concludes there is an irrebuttable presumption pursuant to PRM-1 § 1004 that Alpha was related to SHHC-L during the period of time SHHC-L was owned by Gayle Rogers' brother-in-law, Robert Lee. The Court also concludes there is an irrebuttable presumption that Alpha was related to SHHC-ET during the period of time SHHC-ET was owned by Gayle Rogers' brother-in-law, Stephen McDonough.

In their brief in opposition [Court File No. 77], defendants raise various arguments. These arguments are without merit. The Court agrees with the plaintiff's position and analysis of the applicable law. [Court File Nos. 35, 83]. Moreover, the Court concludes that the government's interpretation of PRM-1 §§ 1004 and 1004.2, as applied here to the defendants based on the facts of this case, is not so novel or arbitrary that it deprives the defendants of fair notice and their constitutional right to due process of law.

IV. Reasonableness of Alpha's Management Fees: Plaintiff's Motion in Limine [Court File No. 36] *and Plaintiff's Motion to Limit Discovery [Court File No. 37]*

***30** Plaintiff makes a motion in limine to exclude all evidence and argument at trial concerning the purported reasonableness of Alpha's management fees. Plaintiff contends that whether Alpha's management fees were reasonable and fair in comparison to management fees usually charged by other suppliers in the open market is not relevant to the plaintiff's claims or any legal defense to those claims. It is argued that if Alpha and the Superiors were related under 42 C.F.R. § 413.17, then the only relevant inquiry is whether Alpha's costs in managing the Superiors were reasonable without taking into consideration any profit to Alpha. *Shaker Medical Center,* 686 F.2d at 1205 (the regulation looks not to what the Medicare provider paid for the service, but rather to the cost to the related supplier). Conversely, if it is determined at trial that Alpha and the Superiors were not related, then it would be unnecessary for the Court to address the issue of the reasonableness of Alpha's management fees.

The motion in limine DENIED because the reasonableness of Alpha's management fees is relevant to deciding the issue whether Alpha and the Superiors were related. Plaintiff contends that Alpha was related to the Superiors on the theory that Alpha and William Rogers had control over the Superiors within the meaning of 42 C.F.R. § 413 .17(b). Control exists if Alpha and its owner, William Rogers, had the power, directly or indirectly, significantly to influence or direct the actions or policies of the Superiors. 42 C.F.R. § 413.17(b)(3). PRM-1 § 1004.3 states that the term "control" means any kind of control, whether or not it is legally enforceable, and however it is exercisable or exercised.

In *Crook County Memorial Hospital v. Blue Cross and Blue Shield Association of Wyoming,* PRRB Hearing Decision No. 87-D91, *reprinted in* CCH Medicare and Medicaid Guide ¶¶ 36, 430 (July 29, 1987), the PRRB found that a comparison study showing the Medicare provider's costs were substantially higher and out of line compared with the costs of similar providers was evidence of relatedness between the provider and its management company. As a matter of logic and common sense, the converse of the rationale expressed by the PRRB in *Crook County Memorial Hospital* should also apply in the instant case. If the defendants can present proof that the management fees Alpha charged to the Superiors in 1990-1993 were reasonable and fair, it tends to prove that Alpha and William Rogers did not exercise control and significant influence over the Superiors. *See also* HCFA Administrator Decision, *reprinted in* CCH Medicare and Medicaid Guide ¶ 29,622 (Feb. 9, 1979) (where contract between parties was consistent with usual financing arrangements in the open market, there was But this would be only one of numerous factors to be taken into consideration by the jury at trial and would not necessarily be dispositive.

It would be manifestly unfair and illogical for HCFA and the PRRB to be able to say that unreasonably high, expensive management fees are evidence of control and relatedness but that reasonable, fair management fees may not also be considered as proof of lack of control by the management company over the Medicare provider. Therefore, the defendants may present evidence and arguments at trial regarding the reasonableness of Alpha's management fees in 1990-1993 but only for the narrow, limited purpose of litigating the issue whether Alpha and William Rogers had control over the Superiors such that Alpha was related to the Superiors pursuant to 42 C.F.R. § 413.17 and PRM-1 §§ 1000--1004.4.

***31** The defendants may not seek to introduce evidence of the reasonableness of Alpha's management fees for any other purpose. If the jury finds at trial that Alpha and the Superiors were related pursuant to 42 C.F.R. § 413.17, then the reasonableness of Alpha's management fees becomes irrelevant as to any other issues. *See Kidney Center of Hollywood,* 133 F.3d at 86. This same subject is discussed and analyzed *supra* in section II.E of this opinion. At trial, the Court will give the jury a special instruction that evidence concerning the alleged reasonableness of Alpha's management fees may only be considered for the sole purpose of determining whether Alpha was related to the Superiors.

Plaintiff correctly points out that 42 C.F.R. § 413.17(d) sets forth a limited exception to the general cost principle. For the exception to apply, all four criteria listed in § 413.17(d)(1) must be met. One of these criteria is that the Medicare provider must demonstrate by convincing evidence that the charge to the provider is in line with the charge for such services in the open market and no more than the charge made under comparable circumstances to others by the organization for such services. § 413.17(d)(1)(iv). This particular criteria concerns the reasonableness of Alpha's management fees in comparison to the cost of management services by other organizations in the open marketplace where those organizations are not related to the Medicare provider.

However, we need not reach and consider § 413.17(d)(1)(iv) because the defendants have not satisfied another essential prong of the exception in § 413.17(d)(1)(ii). For the exception to apply, 42 C.F.R. § 413.17(d)(1)(ii) provides that a substantial part of the supplier's business activity (here Alpha's business activity) of the type carried on with the Medicare provider (here the Superiors) must be transacted with others than the provider and organizations related to the supplier by common ownership or control. PRM-1 § 1010 .1 explains that the exception in 42 C.F.R. § 413.17(d) "is intended to cover situations where large quantities of goods and services are supplied to the general public and only incidentally are furnished to related organizations." (Emphasis supplied).

Defendants cannot rely on and utilize the 42 C.F.R. § 413.17(d) exception in their defense because they cannot satisfy the criteria in § 413.17(d)(1)(ii). Defendants are unable to show that a "substantial part" of Alpha's business activity of the type carried on with the Superiors, *i.e.,* management services, was transacted by Alpha with others than the Superiors and organizations related to the Superiors by common ownership or control. It is undisputed that on average in 1990-1993, over 85 % of Alpha's revenues came from the Superiors. Alpha only had approximately 15 % of its business activity with organizations other than the Superiors. Thus, Alpha does not meet the exception in § 413.17(d). *Condado Home Care Program, Inc. v. Cooperative De Seguros De Vida,* 775 F.2d 457 (1st Cir.1985) (two-thirds of supplier's business with non-related organizations is not substantial); *Grand Islander Health Care Center v. Heckler,* 573 F.Supp. 405, 411-12 (D.R.I.1983); *American Medical International, Inc. v. Secretary of Health Education and Welfare,* 466 F.Supp. 605 (D.D.C.), *aff'd,* 677 F .2d 118 (D.C.Cir.1981) (supplier having 52 %, 64 %, and 67 % of business with non-related parties for three years was not substantial within meaning of the regulation).

***32** Consistent with the Court's ruling *supra* on the motion in limine, the plaintiff's companion motion to limit discovery on the reasonableness of Alpha's management fees [Court File No. 37] is likewise DENIED. On March 2, 1999, Magistrate Judge John Powers rendered a memorandum opinion and order denying the motion to limit discovery. [Court File No. 89]. Plaintiff filed objections to the Magistrate Judge's ruling under FED. R. CIV. P. 72(a). [Court File No. 91]. The Court has reviewed the record de *novo.* The plaintiff's objections are DENIED. The Court finds that the Magistrate Judge's ruling is neither clearly erroneous nor contrary to law. The Court agrees with the Magistrate Judge's analysis and decision.

With regard to the motion to limit discovery, the defendants have raised certain issues which require some discussion and clarification. [Court File Nos. 84, 97]. Defendants contend evidence that Alpha's management fees were reasonable is relevant because it tends to prove that the defendants did not act "knowingly" in violation of the FCA. This goes to the scienter element of the FCA causes of action. The Court rejects this argument. Defendants have not cited, and the Court is not aware of, any legal precedent which stands for the proposition that the alleged reasonableness of Alpha's fees is relevant to the issue of whether the defendants violated the FCA by knowingly submitting false or fraudulent claims to the government. Whether the defendants acted "knowingly" does not depend on the reasonableness of Alpha's fees. Instead, the scienter element and the issue whether the defendants acted knowingly for purposes of the FCA depends on whether the defendants knew that Alpha was related to the Superiors under the Medicare regulations and knew that the Superiors were making false or fraudulent claims to the government seeking Medicare reimbursement for the full cost of Alpha's management fees for which the Superiors had no lawful right to be reimbursed. The reasonableness of Alpha's management fees is immaterial.

Next, defendants assert that the reasonableness of Alpha's management fees is relevant to calculating damages. Defendants ask the Court to view damages from the perspective of what the Superiors would have paid for the cost of management services in 1990-1993 if the Superiors had not hired Alpha and had instead contracted with a different management company. The defendants' theory is that to measure and determine the amount of actual damages suffered by the government, the Court should take the amount of reasonable management fees charged to the Superiors by Alpha and subtract it from the cost of reasonable management fees the Superiors would have otherwise had to pay to a non-related management company on the open market in 1990-1993 in an arm's length contract. This argument is fatally flawed because it is based on an erroneous method for measuring damages.

The FCA itself does not specify how to measure damages. Fraud comes in many varied forms and there is no set formula for calculating damages set forth in the FCA. Because each case under the FCA case involves unique circumstances and types of damage to the government, the Court must devise a proper standard for measuring the damages directly caused to the government by the filing of a false claim. Damages have been measured by the courts in a variety of ways, and the method of measurement is influenced by the nature of the fraud and the type of government transaction affected by the fraud. *United States v. Cabrera-Diaz,* 106 F.Supp.2d 234, 239 (D. Puerto Rico 2000); *United States ex rel. Roby v. Boeing Co.,* 79 F.Supp.2d 877, 884-85 (S.D.Ohio 1999). Damages awarded under the FCA are liberally calculated to ensure that they afford the government complete indemnity and restitution for the financial harm it has suffered. The purpose of the FCA is to make the government completely whole. *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 549 (1943); *United States ex rel. Compton v. Midwest Specialties, Inc.,* 142 F.3d 296, 304 (6th Cir.1998); *Cabrera-Diaz,* 106 F.Supp.2d at 239. Ordinarily the proper measure of damages in a FCA case is the difference between what the government actually paid out by reason of the false claim over and above what it would have paid had the government known the true facts. *Hess,* 317 U.S. at 543-44; *United States v. Woodbury,* 359 F.2d 370, 379 (9th Cir.1996); *Roby,* 79 F.Supp.2d at 885.

***33** The instant case involves a complaint by the government of overpayment. The government contends that as a result of the defendants making false or fraudulent claims in violation of the FCA, HCFA paid out more money than it should have to the Superiors for Medicare provider cost reimbursements. The government seeks to recover restitution for the overpayments. If Alpha and the Superiors were related under 42 C.F.R. § 413.17, then the Superiors were entitled to be reimbursed by the Medicare program only for Alpha's actual costs, not including a profit. The government's damages equal Alpha's profit. To correctly measure and calculate the government's damages in this case, the amount of Alpha's actual costs should be deducted from the total amount of money that HCFA disbursed to the Superiors to reimburse them for Alpha's management fees. The reasonableness of Alpha's management fees in comparison to similar fees charged by other non-related management organizations on the open market is not relevant to the issue of damages.

Defendants argue that the reasonableness of Alpha's management fees is relevant because it supports their defense that there are "special circumstances" which preclude application of Medicare's related-party rule in this case. The Court has already discussed and rejected the "special circumstances" exception advocated by the defendants. The judicially created "special circumstances" exception, which is equitable in nature, is inapplicable here because this is an action involving claims of fraud brought under the FCA and common law. If the plaintiff is able to prove that the defendants violated the FCA and knowingly submitted false and/or fraudulent claims to the government, then the defendants are not entitled to any equitable relief under the "special circumstances" exception.

V. *Plaintiff's Request for Oral Argument [Court File No. 183]*

The plaintiff's request for oral argument is DENIED. Plaintiff has not demonstrated that there is a genuine need for oral argument. The parties have filed exhaustive, repetitive briefs on every conceivable issue. At this point the Court does not have any questions for counsel. Oral argument would not substantially assist the Court in ruling on the pending motions.

VI. *John Konvalinka as Prospective Witness*

It appears that attorney John Konvalinka may be a witness at trial. If Mr. Konvalinka is going to be called to testify at trial, it may be necessary for him to withdraw as counsel of record for defendant Charitable. The Court respectfully directs the parties' attention to Disciplinary Rules 5-101 and 5-102 of the Tennessee Code of Professional Responsibility set forth in Rule 8, RULES OF THE SUPREME COURT OF TENNESSEE. The United States District Court for the Eastern District of Tennessee has adopted the same Code of Professional Responsibility. E.D.TN LR 83.6. This Court has no doubt that Mr. Konvalinka, being an experienced lawyer, has already given this subject considerable thought and attention.

***34** The question of whether Mr. Konvalinka needs to withdraw as counsel must be addressed as soon as possible so that it does not interfere with the trial schedule. It may be that the parties can reach stipulations which would make it unnecessary for Mr. Konvalinka to be a witness. The Court encourages the parties to discuss and explore in good faith the possibility of appropriate stipulations which would obviate the need for Mr. Konvalinka to testify at trial.

In any event, the Court will require the parties to advise the Court of their respective positions. On or before July 27, 2001, the plaintiff and the defendants shall each file written statements with the Court stating: (1) whether they intend to call John Konvalinka as a witness at trial; and (2) if so, a summary of the specific issues on which they anticipate that Mr. Konvalinka would be expected to testify; and (3) whether such issues are contested or uncontested. Once the Court has had an opportunity to review these statements, the Court may later direct the parties to submit memoranda of law. The parties shall not file memoranda of law and present any legal arguments at this time.

VII. *Bifurcation of Liability and Damages at Trial*

The Court is contemplating whether to bifurcate the issues of liability and damages at trial. Before reaching a decision on bifurcation, the Court will afford the parties an opportunity to file memoranda expressing their respective positions and opinions on the subject. On or before July 27, 2001, each party shall each file a memorandum of law with the Court explaining their position on the question of bifurcating liability and damages at trial.

SO ORDERED.

2001 WL 818160 (E.D.Tenn.)

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